

§ 403.306

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any reduced payments to hospitals under the system that result from this cost-effectiveness assurance will constitute full and final payment for hospital services furnished to Medicare beneficiaries for the period covered by these reduced payments.

§ 403.306 Additional requirements for State systems—mandatory approval.

(a) *General policy*—(1) *Mandatory approval.* HFCA will approve an application for Medicare reimbursement under a State system if the system meets all of the requirements of § 403.304 and of paragraph (b) of this section.

(2) *Exception.* CMS may approve an application if the State system meets all of the requirements of § 403.304 but only some of the requirements of paragraph (b) of this section.

(b) *Additional requirements*—(1) *Operation of system.* The system must—

(i) Be operated directly by the State or by entity designated under State law;

(ii) Provide for payments to hospitals using a methodology under which—

(A) Prospectively determined payment rates are established; and

(B) Exceptions, adjustments, and methods for changes in methodology are set forth;

(iii) Provide that a change by the State in the system that has the effect of materially changing payments to hospitals can take effect only upon 60 days notice to CMS and to the hospitals likely to be materially affected by the change and upon CMS's approval of the change.

(2) *Satisfactory assurances*—(i) *Admissions practice.* The State must assure that the operation of the system will not result in any change in hospital admission practices that result in—

(A) A significant reduction in the proportion of patients receiving hospital services covered under the system who have no third-party coverage and who are unable to pay for hospital services;

(B) A significant reduction in the proportion of individuals admitted to hospitals for inpatient hospital services for which payment is less, or is likely to be less, than the anticipated charges for or cost of the services;

(C) A refusal to admit patients who would be expected to require unusually costly or prolonged treatment for reasons other than those related to the appropriateness of the care available at the hospital; or

(D) A refusal to provide emergency services to any person who is in need of emergency services, if the hospital provides the services.

(ii) *Consultation with local government officials.* The State must provide documentation that it has consulted with local government officials concerning the impact of the system on publicly owned or operated hospitals.

§ 403.308 State systems under demonstration projects—mandatory approval.

CMS will approve an application from a State for a State system if—

(a) The system was in effect prior to April 20, 1983 under an existing demonstration project; and

(b) The minimum requirements and assurances for approval of a State system are met under § 403.304 (b)(1)–(10) and § 403.304(c), and, if appropriate § 403.304(d).

§ 403.310 Reduction in payments.

(a) *General rule.* If CMS determines that the satisfactory assurances required of a State under § 403.304(c) and, if applicable, § 403.304(d) have not been met, or will not be met, with respect to any 36-month period, CMS will reduce Medicare payments to individual hospitals being reimbursed under the State's system or, if applicable, under the Medicare payment system, in an amount equal to the amount by which the Medicare payments under the system exceed the amount of Medicare payments to such hospitals that otherwise would have been made not using the State system. The amount of the recoupment will include, when appropriate, interest charges computed in accordance with § 405.378 of this chapter.

(b) *Recoupment procedures.* The amount of the overpayment will be recouped on a proportionate basis from each of those hospitals that received payments under the State system that exceeded the payments they would

have received under the Medicare payment system. Each hospital's share of the aggregate excess payment will be determined on the basis of a comparison of the hospital's proportionate share of the aggregate payment received under the State system that is in excess of what the aggregate payment would have been under the Medicare payment system. Recoupments may be accomplished by a hospital's direct payment to the Medicare program or by offsets to future payments made to the hospital.

(c) *Alternative recoupment procedures.* As an alternative to the recoupment procedures described in paragraph (b) of this section and subject to CMS's acceptance, the State may provide, by legislation or legally binding regulations, procedures for the recoupment of the amount of payments that exceed the amount of payments that otherwise would have been paid by Medicare if the State system had not been in effect.

(d) *Rule for existing Medicare demonstration projects.* In cases of existing Medicare demonstration projects where the expenditure test is to be applied by a rate of increase factor, the amount of the excess payment will be determined, for the three hospital cost reporting periods beginning before October 1, 1986, by a comparison of the State system's rate of increase to the national rate of increase. Recoupment of excessive payments will be assessed and recouped as described in this section.

[51 FR 15492, Apr. 24, 1986, as amended at 61 FR 63748, Dec. 2, 1996]

§ 403.312 Submittal of application.

The Chief Executive Officer of the State is responsible for—

- (a) Submittal of the application to CMS for approval; and
- (b) Supplying the assurances and necessary documentation as required under §§ 403.304 through 403.308.

§ 403.314 Evaluation of State systems.

CMS will evaluate all State applications for approval of State systems and notify the State of its determination within 60 days.

§ 403.316 Reconsideration of certain denied applications.

(a) *Request for reconsideration.* If CMS denies an application for a State system, the State may request that CMS reconsider the denial if the State believes that its system meets all of the requirements for mandatory approval under §§ 403.304 and 403.306 or, in the case of a State with a system operating under an existing demonstration project, the applicable requirements of §§ 403.304 and 403.308.

(b) *Time limit.* (1) The State must submit its request for reconsideration within 60 days after the date of CMS's notice that the application was denied.

(2) CMS will notify the State of the results of its reconsideration within 60 days after it receives the request for reconsideration.

§ 403.318 Approval of State systems.

(a) *Approval agreement.* If CMS approves a State system, a written agreement will be executed between CMS and the Chief Executive Officer of the State. The agreement must incorporate any terms of the State's application for approval of the system as agreed to by the parties and, as a minimum, must contain provisions that require the following:

(1) The system is operated directly by the State or an entity designated by State law.

(2) For purposes of the Medicare program, the State's system applies only to Medicare payments for inpatient, and if applicable, outpatient hospital services.

(3) The system conforms to applicable Medicare law and regulations other than those relating to the amount of reimbursement for inpatient hospital services, or for inpatient and outpatient services, whichever the State system covers. Applicable regulations include, for example, those describing Medicare benefits and entitlement requirements for program beneficiaries, as explained in parts 406 and 409 of this chapter; the requirements at part 405, subpart J of this chapter specifying conditions of participation for hospitals; the requirements at part 405, subparts A, G, and S of this chapter on Medicare program administration; and